2018 CAMP MAGICAL MOMENTS

Cancer Camp for Kids, Inc.

NEW VOLUNTEER APPLICATION

(MUST BE 21 YEARS OF AGE OR OLDER TO APPLY)

Personal Information

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Male/Female: _____Date of Birth: _____ Soc. Sec. No.: _____
Home Phone: _____Work Phone: _____
Cell Phone:_____ Email Address:_____
Drivers License #_____ State_____
Highest level of education attained: (circle) High School: 9—10—11—12
College: 1—2—3—4
Graduate School/Degree Earned: _____
Medical/Health Training: (circle any that you have) RN LPN CPR EMT First Aid Cert. Lifeguard
Medical/Health Training: List institutions, medical/health degrees, certifications, year received:
_____
_____
List other certification or training useful at camp _____
T shirt size (circle one) Adult – S – M – L – XL - XXL

Employment Information

Employer: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Position/Title: _____ Supervisor: _____

Camp Information

How did you hear about Camp Magical Moments? _____
_____

Why would you like to volunteer for Camp? _____
_____

What would you like to do as a Camp volunteer? _____
_____

List any experiences you have had with children: _____
_____

Describe your camping knowledge and experiences: _____
_____

Describe any experience you may have working with the physically or emotionally disabled: ___
_____

What experience(s) have you had with cancer or with cancer patients? _____
_____

Describe any special interests, skills, or workshops you would be willing to share at camp: i.e., photography, face painting, juggling, singing, playing musical instrument, etc. _____
_____

Staff Assignments will be made by the Director and the Volunteer Director. Below is a list of areas that staffing will be needed. Please indicate where you feel that you could best serve the camp. Please rate 1 through 9. 1 would be the area where you feel you would be most helpful and 9 the least. Enclosed is a list of job descriptions to help you with your decision.
Cabin Counselor _____Kitchen _____ Arts & Crafts _____Climbing Wall _____
Horse Program ____ Team Building____ Music ____Medical Staff ____ Archery _____
Other _____

Have you previously been accepted as a volunteer at a children's camp? _____
If yes, when? _____ If yes, what was your position? _____
If yes, explain some of your most meaningful experiences: _____
_____
_____

If you are asked to have a driving responsibility, do you have a valid driver's license? Yes No
Driver's License No. _____ State _____ Exp. Date _____

Have you had your driver's license suspended or revoked in the last three (3) years? Yes No
If yes, give details _____
_____

Consent Agreement, Authorization and Release

This Consent Agreement, Authorization and Release must be read and signed by the Applicant in order for you to be eligible to attend Camp Magical Moments.

Consent for Medical Treatment

The Undersigned hereby grants permission to the medical staff and/or consulting physicians at Camp Magical Moments to administer medication and provide medical care, including any medical emergency care required. Undersigned also gives consent for any emergency transportation deemed necessary. Undersigned accepts financial responsibility for the expenses arising from this consent.

Media Consent

I give Camp Magical Moments permission to photograph me and to use any pictures taken of me during Camp in photographs, audio/visual tapes, or materials written for professional or fund-raising activities through any medium including print, television, radio or the Internet. _____
please initial

Property Damage

It is understood that the cost of repair or replacement of facilities or property that is damaged by me will be reimbursed by me to Camp Magical Moments. _____
please initial

Release of Liability

The undersigned understands that occasionally accidents occur during camp activities and that participants may sustain serious personal injury or death and property damages as a consequence thereof. Knowing the risks of camp activities, nevertheless, and in consideration for participation at Camp, the undersigned hereby agrees to assume those risks and to hold harmless the Camp Magical Moments, Cancer Camp for Kids, Inc. and all Camp agents, representatives, employees, and volunteers, from any and all liability, claims for personal injury or property damage, costs, expenses, and damages arising out of or connected in any way with my participation in camp activities. Further, the undersigned acknowledges that Camp Magical Moments, Cancer Camp for Kids, Inc. accepts no responsibility for the loss, damage, or theft of my personal property.

I have read, understood and give my consent/release of liability:

Signature: _____ Date: _____

_____

(Printed Name)

IMPORTANT NOTE: According to Camp Magical Moments guidelines, **all medical volunteers must carry medical liability coverage. Proof of coverage must be submitted with this form.** If you do not carry individual coverage, check with your hospital facility. They may extend their coverage to include your participation in Camp.

Emergency Contacts

In the event of an emergency, whom should we contact?

Name: _____ Relationship: _____
Home Phone: _____ Work Phone_____

Name: _____ Relationship: _____ _____
Home Phone: _____ Work Phone: _____

Personal References

Camp Magical Moments requires three personal references that have knowledge of your character, experience, and ability. One reference must be from a child under the age of 18 and the two remaining must be adults. Only one of the three may be from a relative.

Please give a Camp Magical Moments Personal Reference Form to each of your references. Ask them to fill out and return to you so you can submit the references along with this application.

Note: Applications will not be considered without these references.
Please give names and contact information of your references below.

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____
Relationship: _____Child? _____

Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Relationship: _____ Child? _____

Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Relationship: _____Child? _____

Please indicate which of your references a child is and which is a relative. They can be the same reference.

By signing below, I confirm that I have completed this application in good faith and without intent to falsify, misrepresent, and/or omit information, and that the information contained herein is true and correct. I give permission for Camp Magical Moments Medical Staff to administer any routine and/or emergency first-aid. I understand that every effort will be made to contact named emergency persons, but in the event that they cannot be reached I hereby give permission to CMM Medical Staff to acquire medical care and treatment as needed during Camp.

Signature of Applicant/Date

Return the completed application to:
Faye Sledge, Volunteer Director
Camp Magical Moments
P. O. Box 12
Swan Valley, ID 83449
Be sure to include the following items:
Please provide the front and back copy of your insurance card.
Photocopy of your Driver's License
Signed Volunteer Criminal Background Check
3 completed, signed Reference Forms (A, B, &C)
Photocopy proof of medical liability coverage (this applies to medical volunteers only)

APPLICATIONS MUST BE RECEIVED BY February 1st, 2018

VOLUNTEER HEALTH FORM for Name: _____

GENERAL HEALTH HISTORY:

LAST EAR INFECTION _____ (DATE)			MUMPS	YES	NO
HEART PROBLEMS	YES	NO	MEASLES	YES	NO
SEIZURES	YES	NO	GERMAN MEASLES	YES	NO
DIABETES	YES	NO	ASTHMA	YES	NO
CANCER*	YES	NO	HEPATITIS	YES	NO

*IF YES, DIAGNOSIS _____ DATE OF LAST TREATMENT _____
ONCOLOGIST _____
OTHER PHYSICAL CONDITIONS/ISSUES: _____
_____

IMMUNIZATION HISTORY:

DPT SERIES _____ LAST TETANUS BOOSTER _____

BOOSTER _____ LAST TUBERCULIN TEST _____
POLIO BOOSTER _____ OTHER _____
MMR (MEASLES, MUMPS, RUBELLA) _____

ANY INFECTIOUS/COMMUNICABLE DISEASE EXPOSURE? YES NO
If yes, please explain: _____

ALLERGIES: YES NO
HAY FEVER YES NO
INSECT STINGS YES NO
IVY POISONING YES NO
MEDICATIONS YES NO
OTHER YES NO _____

RECOMMENDATIONS/RESTRICTIONS:
DIET: _____
ACTIVITY LEVEL: _____
OTHER: _____

I do not have any medical condition that would exclude me from participation in camp activities. ___True ___False

MEDICATIONS: MEDICATIONS MUST BE BROUGHT IN ORIGINAL PHARMACY CONTAINERS

Drug Dose Time Days of Week

_____

_____

_____

PHYSICIAN INFORMATION

Please provide the following information for us to have on hand in the event of a medical issue.

Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

MEDICAL INSURANCE INFORMATION You are responsible for any and all medical emergency treatment for yourself.

The following information will be used only if medical care and treatment are needed during Camp.

Name of Your Insurance Co.: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy No./Group No. _____